Form
5140.2(b)

TO BE FILLED OUT BY PHYSICIAN

Dear_______________________________________
(Individual(s) Administering Medication)
Please administer the following medication(s) to:

Name of Student_______________________________Address:________________________

Student Telephone No.________________ School:__________________________ Grade:____

Diagnosis____

Physician Medication Orders: ____

DAILY MEDICATIONS

Medicine	Route	Dose	Frequency	Duration	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication: (if none, so state).
				From: To:	
				From: To:	
				From: To:	

PRN MEDICATIONS (as is needed)

Medicine	Route	Dose	Frequency	Duration	Condition under which medication should be given	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication: (if none, so state).
				From: To:		
				From: To:		

I agree to retain the power to direct, supervise, decide, inspect, and oversee the administration of such medication(s). Direct contact shall be made with me at any time should you have any questions.

Hospital/Clinic/Office______________________________________ Phone:________________

Address:____

Physician's Signature:______________________________________ Date:________________